THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3339.M5

MDR Tracking Number: M5-04-3308-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 6-1-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, muscle testing, range of motion, therapeutic exercises, therapeutic procedures, diathermy, electrical stimulation, chiropractic manipulation, biofreeze durable medical equipment, and massage therapy from through were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On August 31, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT Code 95851 on date of service 7-2-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the fee guidelines. (96 Fee Guideline.). Recommend reimbursement of $36.00.

Regarding CPT Code 97139-EU - 9-10-03: According to Rule 134.202 (e)(9), the HCP must utilize correct modifiers. Recommend no reimbursement.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 7-2-03 in this dispute.

This Decision and Order is hereby issued this 30th day of September 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

August 26, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3308-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 22 year-old male suffered an injury to his left ankle and foot on ___ when a wheeled piece of equipment ran over his foot. He had a similar injury ___ as well. His diagnosis is listed as ankle strain and chronic regional pain syndrome and he has been treated with multiple passive and active therapies and pain management since the date of the injury.

Requested Service(s)

Office visits, muscle testing, range of motion, therapeutic exercises, therapeutic procedures, diathermy, electric stimulation, chiropractic manipulation, Biofreeze durable medical equipment, and massage therapy for dates of service 08/26/03 through 10/08/03.

Decision

It is determined that office visits, muscle testing, range of motion, therapeutic exercises, therapeutic procedures, diathermy, electric stimulation, chiropractic manipulation, Biofreeze durable medical

equipment, and massage therapy were not medically necessary for the treatment of this patient's medical condition from 08/26/03 through 10/08/03.

Rationale/Basis for Decision

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*[1] chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four week total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." The treatment rendered prior to the dates in dispute would have been indicated for this patient, but since the patient did not produce the expected positive results and in fact experienced a dramatic decrease in his ankle range of motion during the period from 07/02/03 through 08/26/03, it was not reasonable to continue that course of treatment.

The medical records also fail to substantiate that the disputed treatments fulfilled the criteria for medical necessity as outlined in Texas Labor Code 408.021, since the patient obtained no significant relief, promotion of recovery was not accomplished, and there was no enhancement of the employee's ability to return to employment. Specifically, the patient's pain rating was 5 on a scale of 10 at the initiation of the care in question on 08/28/03 and was 5 on the same scale at the termination of the disputed treatment on 10/08/03. Therefore, it is determined that the office visits, muscle testing, range of motion, therapeutic exercises, therapeutic procedures, diathermy, electric stimulation, chiropractic manipulation, Biofreeze durable medical equipment, and massage therapy were not medically necessary for the treatment of this patient's medical condition from 08/26/03 through 10/08/03.

Sincerely,

[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.